GOVERNMENT OF THE DISTRICT OF COLUMBIA
DEPARTMENT OF HEALTH
HEALTH PROFESSIONAL LICENSING ADMINISTRATION

APPLICATION FOR CERTIFICATION

BOARD OF NURSING
HOME HEALTH AIDE

All applicants must complete every section of this application and submit the original application and all required supporting documents. If more space is needed to fully answer questions, attach additional sheets with typed responses. False or misleading statements will be cause for disciplinary action and could be cause for criminal prosecution pursuant to *DC Code 22-2514*. If you have any questions, call HPLA Customer Service at 1-877-672-2174 Monday through Friday, 8:30 AM to 4:30 PM EST. **Please Note: Please refer to application instructions before completing this form.**

SECTION 1A. CERTIFICATION FEE

☐ **Home Health Aide Certification by Waiver of Examination (Grandfathering)** $50.00

☐ **CRIMINAL BACKGROUND CHECK:** For payment and to schedule an appointment call **1-877-783-4187** or visit www.L1enrollment.com)

☐ **CRIMINAL BACKGROUND CHECK:** Previously completed for licensure/certification by DC Health Professional Licensing Administration (If this applies to you, another CBC is not required)
All applicants are required to undergo a Criminal Background Check

CERTIFICATION EXPIRATION:
HHA Certificates expire October 30th 2015

DEADLINE FOR SUBMISSION OF WAIVER APPLICATION IS: MARCH 15, 2013

Make check or money order payable to: DC Treasurer

SECTION 2A. APPLICANT INFORMATION

LEGAL NAME: ***(Do not use initials unless they are a part of your name)***

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

___/_____/____ _____ - _____ - _____ *
Date of Birth **Social Security Number** **GENDER:** ☐ **MALE** ☐ **FEMALE**

*All Applicants must provide a Social Security Number. If you are a foreign applicant and do not have a SSN or are waiting for one to be issued, you must complete the SSN affidavit form and submit it with your application. Your certification will not be renewed without a valid SSN. You can download the affidavit form by accessing it at www.hpla.doh.dc.gov

SECTION 2B. OTHER NAME USED: (Please print clearly)

If your name on this application is different from the name on your supporting documentation. Provide a copy of a legal name change document. Acceptable documents for individuals are marriage certificates, divorce decrees, court orders and spouse's death certificate.

_____ _____ _____ _____
FIRST NAME **MI** **LAST NAME** **(SUFFIX: Jr., Sr. etc.)**

_____ _____
Place of Birth: State/Providence/Territory **Country if not USA**

SECTION 2C: RACE & ETHNICITY DESIGNATION:

☐ **American Indian/Alaskan Native**
☐ **Asian/South Asian**
☐ **Black or African American**
☐ **Caucasian/White**
☐ **Hispanic or Latino**
☐ **Other** _____
☐ **Native Hawaiian or other Pacific Islander**

LANGUAGE(S) SPOKEN:

Language(s) spoken other than English:

☐ **Spanish** ☐ **French**
☐ **German** ☐ **Arabic**
☐ **Other** _____

SECTION 3A. HOME HEALTH AIDE PROGRAM (MANDATORY)

Name of School	Address	Date Completed

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SECTION 3B. HOME ADDRESS

P.O. BOX MAY NOT BE USED FOR AN ADDRESS. PLEASE PROVIDE A STREET ADDRESS. This will be the address to which all future documents related to your certification will be mailed.

ADDRESS:_____
(Street Number and Street Name) (City) (State/Province/Territory) (Zip Code)

APARTMENT #_____ **PHONE NUMBER: (**_____**)** _____ **-** _____ **FAX: (**_____**)** _____ **-** _____

You are statutorily required to notify the DC Board of Nursing in writing of an address change within 30 days. Failure to do so may result in your not receiving your certificate, renewal notice or other official notices and can result in a disciplinary action or a fine.

EMAIL ADDRESS (Please provide) : _____ **CELL PHONE:** _____

SECTION 3C. CURRENT EMPLOYER (s) (MANDATORY)

Name	Address	Hire Date

SECTION 3D. CURRENT STATE CERTIFICATION/PRACTICE

STATE	ACTIVE/ NOT ACTIVE	CERTIFICATION NUMBER (if applicable)	

SECTION 4. FEES AND SUPPORTING DOCUMENTS

☐ **HOME HEALTH AIDE CERTIFICATION FEE:** **$50.00** **CRIMINAL BACKGROUND CHECK FEE:** **$50.00 (Please note: Some states may add an additional fee)**

☐ **CRIMINAL BACKGROUND CHECK:** **-To schedule your live scan fingerprints visit www.L1enrollment.com [now MorphoTrust] or call 1-877-783-4187. For questions contact the CBC unit at 202-442-9004. Please Note: You must submit this application and obtain your certification number prior to registering for your fingerprint live scan. You can obtain your certification number at http://app.hpla.doh.dc.gov/weblookup 72 hours after your application has been submitted.**

Your application along with all required supporting documents must be mailed in the same package to the Board office. Please mail in a 9X12 inch envelope and do not staple or fold application.

☐ **Passport-Type Photos - Two recent and identical passport-type photos of the applicant's face (approx. 2"X2") with applicant's name printed on the back. The photos must be original photos and cannot be computer-generated copies or paper copies.**

☐ **Copy of legal document supporting name change (if applicable). Acceptable documents are marriage certificate, divorce decree, court order or spouse's death certificate.**

☐ **SSN Affidavit Form (if no SSN issued) This document can be found at www.hpla.doh.dc.gov**

☐ **Provide a detailed explanation if you answer "Yes" to any of the questions in Section 5. Submit copies of personnel action (e.g. termination due to unsafe practice) actions taken against your license/certification or other relevant documents.**

☐ **Home Health Aide Attestation Form to be completed by your employer and supervising nurse/health professional**

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SECTION 5. SCREENING QUESTIONS Applicants must answer all of the following questions

Clean Hands Before Receiving a License or Permit Act of 1996 Certification Form Requirement

Please read the information below carefully before responding to this yes or no question, as **any false information provided requires that the Department of Health proceed immediately to revoke your Certification** for which you are now applying, and fine you one thousand dollars ($1,000.00), pursuant to D.C. Official Code § 47-2864 (2001).

PLEASE NOTE: Pursuant to D.C. Official Code §47-2862(a) (FY 2007 Budget Support Act of 2006) you cannot be certified if you have failed to file your District tax returns.

IF YOU ANSWER "YES" TO THIS QUESTION, PLEASE SUBMIT PROOF OF THE ARRANGEMENTS YOU HAVE MADE TO PAY THE OUTSTANDING DEBT. IF YOU DO NOT HAVE AN APPROVED PAYMENT SCHEDULE TO PAY THE AMOUNT YOU OWE OR IF NO APPEAL IS PENDING, THE LAW REQUIRES THAT YOUR RENEWAL APPLICATION BE DENIED.

	As of this date, do you owe more than one hundred dollars ($100.00) to the District of Columbia Government as a result of any of the following: 1. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 8, Chapter 8 (Litter Control Administrative Act of 1985); 2. Fines or interest assessed pursuant to D.C. Official Code Title 8, Chapter 9 (Illegal Dumping Enforcement Act of 1994); 3. Fines, penalties, or interest assessed pursuant to D.C. Official Code Title 2, Chapter 18 (Civil Infractions Act of 1985); 4. Past due taxes; 5. Past due District of Columbia Water and Sewer Authority service fees; or 6. Fines or penalties assessed pursuant to D.C. Official Code Title 50, Chapter 23 (Traffic Adjudication)?	YES ☐ NO ☐
A.	Has the use of drugs and/or alcohol resulted in an impairment of your ability to safely provide patient care?	YES ☐ NO ☐
B.	Do you have a mental condition that currently impairs your ability to safely provide patient care?	YES ☐ NO ☐
C.	Have you ever been arrested, or pled guilty instead of going to trial, or been found guilty after a trial, or pled nolo contendere, regardless of whether the arrest, conviction or plea of nolo contendere was sealed or expunged?	YES ☐ NO ☐
D.	Please answer with respect to DC or any other jurisdiction/state: (1) Have you withdrawn an application to practice your profession or voluntarily surrendered a license/certification after formal charges have been filed against you or while under investigation? (2) Have you been (or are you currently being) investigated by any authority or peer review board for any violation of state, federal, or local law?	YES ☐ NO ☐

SECTION 6. LICENSEE AFFIDAVIT

I hereby attest that the information given in this application, including all writings and exhibits attached hereto, is true and complete to the best of my knowledge. I understand that the making of a false statement on this application, including all writings and exhibits attached hereto, is punishable by criminal penalties.

_____ _____ _____

SIGNATURE ***PRINT NAME*** ***DATE***

***PLEASE NOTE: PRINT AND MAIL ORIGINAL APPLICATION TO THE BOARD OF NURSING AND RETAIN A COPY FOR YOUR FILES.**

To report waste, fraud, or abuse by any DC Government office or official, call the DC Inspector General at 1-800-521-1639.

IMPORTANT CONTACT INFORMATION

District of Columbia Health Professional Licensing Administration
Attention: Board of Nursing
899 North Capitol Street, N.E., 1st Floor
Washington, D.C. 20002

Website: www.hpla.doh.dc.gov Fax: (202)724-5145 Customer Service:1(877)672-2174
Criminal Background Check (CBC) Unit Email: doh.cbcu@dc.gov Board Email: bon.dc@dc.gov

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HOME HEALTH AIDE ATTESTATION OF TRAINING AND COMPETENCE

The form is to be completed by your employer and supervising nurse or health professional.

Name of HHA Applicant	Place of Employment (name of office/agency/facility)	Location of Employer	Hire Date End Date
			___/___/____ MM DD YYYY ___/___/____ MM DD YYYY

I, this APPLICANT'S EMPLOYER, confirm that this applicant has successfully completed training as a Home Health Aide at the following training program: ☐ Yes ☐ No

_____

I, this APPLICANT'S EMPLOYER, confirm that to the best of my knowledge, this applicant is competent to provide patient care: ☐ Yes ☐ No

I, this APPLICANT'S EMPLOYER, confirm that to the best of my knowledge, this applicant is competent to provide patient care: ☐ Yes ☐ No

I, the APPLICANT'S EMPLOYER, confirm that this applicant has worked at least 500 hours as an HHA.
☐ Yes ☐ No (If no, how many hours has this applicant worked in your employ? _____)

Employer: _____
[Print your name]

By signing this attestation, I, _____, hereby attest that the information that I have provided on this HHA Attestation Training and Competence Form is true and complete to the best of my knowledge. I understand that making a false statement on this document, including all writings and attachments, may result in the Department of Health taking action against me that it deems appropriate.

I, this APPLICANT'S SUPERVISING NURSE/HEALTH PROFESSIONAL, confirm that this applicant is competent to provide patient care. ☐ Yes ☐ No

Supervising Nurse/ Health Professional: _____
[Print your name]

DC License Number:_____

By signing this attestation, I, _____, hereby attest that the information that I have provided on this HHA Attestation Training and Competence Form is true and complete to the best of my knowledge. I understand that making a false statement on this document, including all writings and attachments, may result in the Department of Health taking action against me that it deems appropriate.